DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Indian Health Service
Rockville, Maryland 20887

Refer To:OHP/CHS

CONTRACT HEALTH SERVICE FUND CONTROL

Sec.

1. PURPOSE

This circular provides the Indian Health Service (IHS) policies and procedures to govern Contract Health Services (CHS) fund control activities and describes managed care practices. The circular standardizes the requirements and procedures to improve the fund management of the IHS CHS program nationwide. It supplements the-Indian Health-Manual, Part II, Chapter 3, CHS and is consistent with the regulations contained in subpart B and C of 42 Code of Federal Regulations (CFR) 36.

2. Background

The IHS mission is to elevate the health status of American Indians and Alaska Natives to the highest level possible. The IHS strives to ensure equity, availability and accessibility to a comprehensive high quality health care delivery system, while providing maximum involvement *of* American Indians and Alaska Natives in defining their health needs, setting health priorities, and managing and controlling their health program. The IHS acts as a principal health advocate for Indian people by insuring they have knowledge of and access to all Federal, State, and local health programs they are entitled to as American citizens. It is also the responsibility of the IHS to work with these programs so they are cognizant **of** entitlements of Indian people.

The major components of the IHS health care delivery system are (1) direct health care services provided by IHS service units or tribal programs, and (2) CHS provided by non-IHS health care providers. The direct health care delivery system is composed of both IHS and tribally operated hospitals, clinics, and health stations. The CHS program provides medical care to eligible American Indians and Alaska Natives which cannot be provided through the direct health care delivery system.

Distribution: PSD 557 (Indian Health Mailing Key)
Date: June 13, 1991

Funds *for* CHS are appropriated by the *Congress.* The IHS allocates these CHS funds through each Area Office, to service units and participating tribal health programs. The IHS is not an entitlement program and is required to operate within appropriated funds. The CHS funds are authotized *for* health-care services under a medical priority system with allowance for high cost illnesses made through the Catastrophic Health Emergency Fund (CHEF) established by the Indian Health Care Amendments of 1988, Public Law (P.L.) 100-713, section 202. In addition, to supplement the CHEF, the IHS uses authorization of P.L. 87-693, to recover from tortuously liable third parties the cost of hospital and medical care and treatment furnished to the injured person.

Access to CHS in the IHS delivery system is through referral by the IHS service unit clinical staff, contracts, or *emergency* contact with the non-IHS provider. While IHS physicians must refer patients for medically indicated care, a referral does not authorize payment for the medical care delivered. This includes referrals for medical services which cannot be provided directly through the existing IHS health care facilities. Because funds are limited by finite annual appropriation, and because some CHS medically indicated referrals are not within established and funded medical priorities, some referrals cannot be paid with CHS funds. When payment *for* medical care is not authorized but is sought by a patient or provider, a denial for payment of medical services is made according to the IHS CBS regulations found in 42 CFR 36.21 et seq. Denial of payment may also be made for other reasons, such a8 lack of eligibility, or availability of an alternate resource.

Patients are financially responsible for care procured in a manner not specifically described in the CFR, 42 CFR 36.21 et seq. For example, IHS would not be financially responsible for (1) medical care obtained upon the advice and/or referral by an IHS practitioner which is outside the CHS medical priorities, (2) when the patient was advised prior to the provision of care that he/she will be financially responsible, and/or (3) referred patient8 who are ineligible for CHS.

The IHS has a responsibility to assist Indian patients in obtaining non-IHS alternate health care resource8 to pay for health care *for* which they are eligible, or would be eligible if they applied.

The IHS payment policy issued in 51 FR 23540 on June 30, 1986 is used to pay the hon-IHS health care provider for medical services meeting the CHS requirement5 for payment. This payment policy requires the IHS to contract with non-IHS health care providers to obtain rates *for* health care services at a cost not to exceed the Medicare allowable rates.

In September 1986, the IHS contracted with an experienced organization to establish a Fiscal Intermediary (FI) function for the IHS CHS to process claims using the Medicare Diagnostic Related Grouping payment methodology. The FI assisted the IRS in implementing the payment policy and enhanced the overall administrative support of the CHS program.

3. POLICY

Each IHS Area and service Unit shall manage and administer its allocated CHS funds within its budget authority as specified in the official advice documents while utilizing managed care principles. The intent of managed care is to improve patient care through maximizing the use of CHS funds. The management function8 of planning, organizing, directing, controlling, coordinating, and evaluating all lend themselves to carrying out the stated intent.

The managed care element8 to be implemented in the CHS program will include at a minimum the following provider data analysis, quality assurance, a disciplined referral process; pre-admission screening concurrent and post-discharge review; discharge planning; prior authorization system and contractual or negotiated rate arrangements with providers.

The Area Director, Area Chief Medical Officer (CMO), Area CHS Officer, Service Unit Director, Clinical Director, and service unit line managers must operate the CHS program to comply within the following objectives:

e. Fund8 are used to provide health care consistent with established CHS medical priorities set by the Director, IRS in concert with the Area CMO, IHS and reflected in the Area medical priority operating guidelines;

B. CHS funds are expended at a consistent rate throughout the entire fiscal year to prevent radical change8 in the level of medical care provided throughout the year; and

C. Adherence to appropriate laws, regulations, and acquisition operating instructions is absolute.

Periodic self-assessment, along with scheduled Headquarters and Area reviews, will be conducted to ensure compliance.

4. RESPONSIBILITIES

A. Headcuarters

1) The Director, IHS shall manage the IHS CBS fund in a manner that does not allow the agency to be deficient in any appropriation during each fiscal year.

2) The Deputy Director, IHS is responsible for ensuring the management of the CHS program nationwide through the Area Directors.

3) The Associate Director Office of Health Programs, IHS is responsible for the CHS program at the Headquarters level through the Division of Health Care Administration/Contract Health Service8 and CHS Branch program accountability.

Areas

The Area Director, Service Unit Director, and tribal contractor are responsible for the operating management of the CHS program budgets at the Area, service unit, and tribal facility level.

AREA/SERVICE UNIT

Several elements require interactive involvement in the process of managing the CHS Program. These elements include data analysis, utilization claims processing, use of the FI, the appeal process, and reporting requirements.

13 Data Analysis: Each level of the organizational structure within the CHS program will develop, implement, monitor and analyze the FI reports and financial report8 generated within the IHS organization on a regular basis. This information will be *used* in managing the program

2) Utilization Reviews Each Area and service unit will monitor utilization trend8 of CHS providers and provide the clinical staff informationon patient admissions and length of stay. Discharge planning will be performed for CHS admissions.

3) Claims Processing: *For* every medical service provided by a non-IHS health care provider for which IHS or the Indian patient has a payment decision responsibility, the service unit shall issue a medical purchase order or a payment denial letter. All purchase orders must be signed, entered into the commitment register and sent to the provider. All denials must be sent to the patient by certified mail, and the respective non-IHS health care provider notified by the service unit.

4) use of the Fiscal Intermediary The FI will be used for the claims payment process for all services, except those specifically excluded by sub-object code classification.

51 Anneal Process: The appeal process for denied CHS claims, as defined in the 42 CFR 36.25 and the IHS CHS Manual, will be followed for reconsideration of the claim when the patient or non-IHS provider initiates the appeal process. This activity will be evaluated with respect to timeliness, appropriateness, and accuracy, when periodic CHS review8 are conducted at the Area and service unit level.

In order for Headquarters CHS to expedite a response to appeals and request8 for information on a specific CHS claim, additional information may be needed from an Area Office. The Area Office staff are to respond within 4 working day8 after receiving a routine request from the CHS claims adjudication staff.

6) Reporting Requirements As part of the IHS oversight of the CHS Fund, all Area Offices, service units, and tribal contractors are required to monitor the obligations and expenditures of CHS sites, and report the results to the Director, IHS. To provide accurate and timely information, the reporting format outlined in section 5 of this circular will be adhered to by the Area Office and the service units.

5. REPORTING **PROCEDURES**

Guidelines for meeting the reporting requirements at the Headquarters, Area, and service unit/tribal contractors levels are in this section. The intent is to ensure uniformity, accuracy, and timeliness of repors to assist in effective management of the CHS program.

A. Headquartere

The Congress occasionally requests a report on the status of IHS CHS including information about the following items: CHEF status; spending rates; projected CHS shortfalls; deferred medical services; and proposed corrective measures to address a projected shortfall.

The IRS CBS report ie prepared by the Division of Health Care Administration/Contract Health Services, Office of Health Programs (OHP), Headquarters **for** the Office of the Director, IHS. This report is a consolidation of the monthly fund status reports submitted by each Area. The Deputy Director, IHS will receive monthly report8 from the Chief, CBS Branch, through the Associate Director, OHP, on the status **of** each Area ***CHS program.*** The Deputy Director, IHS monitors the CBS program of each Area and takes immediate corrective action as soon as report8 suggesting problems are identified.

8. Area

The Area Office CHS monthly **fund** status reports are due in Headquarters, CHS Branch on the 15th day of the month. These Area reports are consolidated into a monthly IHS CHS summary report by the CHS Branch. This summary report is due in the Office of the Director, IHS on the 20th day of the month.

The Area report shall be prepared in the format prescribed in Attachment A. The Area Office is required to use at a minimum, the Standard Health Reporting (SHR)-104 or SHR-111M for consistency in reporting to the CBS Branch, IHS Headquarters. The Area Office monthly ***report*** must be signed by the Area Contract Health Service Officer (CHSO), Area Financial Management Officer (FMO), and Area Director.

The Area Office monthly **report** shall also include a brief narrative discussing any measure5 implemented by the Area to balance the Area CHS budget ***for*** the entire fiscal ***year.*** The Area Director is ultimately responsible for the Area CHS program. The Area Director is required to monitor the CHS program by reviewing the spending rate of each service unit/tribal contract each month. Through the CHSO and CHS staff, immediate action to address identified problems will be undertaken. Spending rates will be calculated on the form using direction8 in Attachment A.

C. Service Unit

The service unit CHS report8 are due in the Office of the ***Area*** Director ***on*** the 7th day of the month. The service unit report must be signed by the **Service** Unit Director, or his/her designee. Each Service Unit should use the SHR-104 or SHR-111M whenever possible (except ***for*** reporting "obligations in process" data) for consistency in reporting to the Area Office.

The report should include a brief narrative discussing measures implemented at the service unit to balance the service unit CHS budget for the entire fiscal year. Spending rates will be calculated-using the format in Attachment A.

It is the responsibility of the Service Unit Director, working with service unit staff, to manage the local CHS program. In order to be effective, the clinical staff and other service unit management staff need to be kept informed of the fund status of the service unit CHS program on % weekly basis. To address this need, each service unit must have a weekly report for use in its day to day management of the CHS program. A summary highlighting the spending rate *and* the statue of available CHS funds for the service unit must be disseminated and discussed with service unit management staff *on a* weekfy basis.

This weekly report is directed toward the day-to-day management of the CHS program funds. Attachment B outlines the steps for this report. The procedures in the outline must be followed to provide validity and consistency of the information provided to the Area Office. Using past fiscal year expenditures and trends for the local service unit CHS program, an ideal spending rate can be developed. Using this as a guide, the present spending rate calculated each week *can* be assessed with respect to meeting the CHS program objectives.

To assist *in* the management of the local CHS program, a Service Unit Resource Management Committee (RMC) must be developed, implemented, and functioning a each service unit. Composition of the RMC should include at minimum representation from the administration, finance, medical staff, and the CHS office. Additional representation from nursing, social services, pharmacy, etc., should be considered. The purpose of the RMC is to assist the Service Unit Director in the day to day decisions regarding the CHS program. The RMC should review local CHS program trends by monitoring referrals, obligations, and reimbursements. The RMC must meet on at least a weekly basis to keep current on the dynamic status of the CHS program. The minute5 of these meetings recording all action taken, must be maintained and reported at regular service unit governing board meeting5 held throughout the year.

D. Tribal Programs

The reporting requirements defined in the regulations for P.L. 93-638 programs will be adhered to by the tribal contractors. Tribal contractors are encouraged to follow the format and submit reports as described under the service unit section above.

6. ADDITIONAL RESOURCE REQUEST PROCEDURES.

Through the use of the Monthly Fund Status Reporting System, the fiscal status of the CHS funds in the service units and the Are% can be readily assessed. When a significant radical change in the level of medical care being provided by an Are% occurs, immediate corrective action will be taken. One of the actions may include a self-assessment of need for Additional CHS funds in that Are%. In that circumstance, in addition to other management activity, a request for additional CHS funds will be required. The following procedures will be used when such a request **is** submitted

A. The Area Office must use the format for the request **as** outlined in Attachment C. The format requires the following elements: basic data; narrative justification; CHEF data; supporting documentation; and historical funding information, Use of the format to support the request for additional funds is mandatory to bring uniformity to the assessment of need done by the Headquarters staff.

B. Additional disbursement of funds require an analysis of the information and data by the Headquarters staff which include representation from CHS; Division of Resource Management; the Associate Director, OHP; and the Deputy Director, IHS.

C. An on-site CHS review by Headquarters CHS and Division of Resource Management staff to assess the need and justification of the request for additional CHS funds, may be required.

7. PRIOR YEAR OBLIGATION REQUEST PROCEDURES.

The circumstances requiring the need for medical care by individuals have no set timeframes, and **as** such, health care services are provided continuously throughout the year. However, the appropriation of CHS funds follow a prescribed ***funding*** period, ***covering*** 12 months from October 1 of one calendar year through September 30 of the following calendar year. When bills for medical care received are delayed because of legitimate factors, processing of payment for these medical services may occur in a different fiscal year than the fiscal year ***when*** the services were actually provided. Requests for prior year funds are necessary for the payment of (1) **claims** that are greater than the established obligation, or (2) bills presented with proper documentary evidence of authorization, but no financial obligation has been recorded.

The most current. procedural guidelines developed and required by the Division of Resource Management, IHS will be used to request funds to pay for prior year obligations.

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ATTACHMENT A

EXPLANATION OF DATA ELEMENTS
CHS FUND STATUS REPORT

The monthly fund status report outlined in the following section is applicable to the Headquarters, Are%, and service unit/tribal program level. The report format is standardized and uses the Lotus Spreadsheet.

Heading

Enter the name of your Are% in the space provided.

Enter the date the report was prepared in the space provided.

Enter the month for which you are preparing the report.

Enter the correct number in the weeks/months columns. Use the reporting reference table to obtain the correct number. It is important that you enter the correct number because they are *used in* the spending plan calculations generated by the Lotus program.

I. SPENDING PLAN

Service Unit Column: List all service units in this column. The last two rows of this column are established for aggregate reporting of P.L. 93-638 CHS contracts and any Area CHS reserve funds.

Column (A) Itemized Allowance Year To Date (YTD). The total annual CHS allowance YTD will be itemized by facility and recorded here. Increases or decreases in the allowance should be reflected here if such action occurs within the reporting period. The amount shall include non-recurring (e.g. deferred services money) and recurring CHS money, but exclude CHEF funds because they are listed separately in column (K).

Column (B). Prior Month Obligationat The total amount obligated for the year to date will be recorded here. This includes deferred services obligations. The SHR-111M will be the source of data for this column. The SHR-11lM is provided to each Area Office on the 7th working day following the end of the month. Use the SHR-111M for the month.

Column (C) Estimated current Monthly Obligations This number is calculated by the Lotus program except October, when this is done manually.

Column (D) Obligations In Process: The total of all outstanding unrecorded items that will be obligated will be listed here. Examples of these are unexpected billed charges by a health *provider* of an eligible CHS referral, mail lag, and laboratory, x-ray, or other ancillary charges of a qualified CHS patient that are pending processing by the service unit.

Column (E) Year to Date Obligations Calculated by the Lotus program.

Column (F) Unobligated Balances Calculated by the Lotus program.

ATTACHMENT A

column (G) Weekly Spending Rate: Calculated by the Lotus program.

Column (H) Projected Obligations Calculated by the Lotus program.

Column (I) Projected Balance Calculated by the Lotus program.

II. REIMBURSEMENTS

Column (J) Number of Catastrophic Cases List the number of catastrophic cases that have occurred to date.

Column (K) Actual CHEF Reimbursements: Record the total amount of CHEF received *85* of this reporting period.

Column (L) Obligations Transferred to CHEF: Record the amount of obligations that have been transferred to CHEF as of this reporting period. Use the SHR-114D form to obtain this information.

column (H) Expected CBEF Reimbursements Record the total amount of *CHEF* reimbursements expected for the cases that are still being processed.

OTHER REPORTING REQUIREMENTS

Answer the questions in the lower portion of the reporting format.

ATTACHMENT A

The following is a SAMPLE of the printout from the spread sheet data entry. This Lotus program has been provided to each of the Area and service unit CHS offices.

ATTACHMENT B

PROCEDURES FOR GENERATING
THE WEEKLY-SERVICE UNIT SPENDING RATE REPORT

Each service unit is given advice of allowance documents by the Area office which provide CHS funds. Using this information, along with the data of daily obligations, reimbursements, and anticipated CHS costs, a spending rate can be calculated. The following steps are recommended for the service unit CHS staff use.

The spending rate for each service unit will be monitored and presented weekly to the Area CHS Officer. Information from weekly reports will be used to generate the Area Monthly FUND STATUS Report (see Attachment A).

The following steps are recommended for calculations for the report:

Add carry-over funds from the previous Quarter (0 in the first quarter);

Add advice of allowance amount from all documents;

Add CHEF reimbursement5 as they are received;

Add positive adjustment for payments less than the obligated amount;

Subtract contracts payable in the quarter;

Subtract any known cost for the quarter. For example, subtract estimated amount **of** cost for obstetric/newborn care during the quarter;

Subtract negative adjustments for payments greater than the obligated amount; and

Subtract any valid obligation ndt entered into the commitment register.

The results of the above transactions estimate the "Total Funds Available" for the Quarter.

An estimate of a weekly spending rate can be determined by dividing the "total FundS Available" by the number of weeks in the Quarter.

nOTE:

All commitments that lead to a liability on the part of the IHS must be considered an obligation and entered into the accounting system as soon as they are identified.

CATASTROPHIC cases must be obligated by each service unit as they occur. All documents for reimbursement from the CHEF must be submitted as soon as the requirements are met. However, the service unit shall not adjust the CHS available balance until the advice of allowance from the Area Office indicating reimbursement from the CHEF is received. After all claims are received and actual reimbursements have been made, any funds provided to the Area/service unit in excess of actual costs incurred must be returned to the Headquarters CHEF program.

ATTACHMENT B

The most current CHEF processing guidelines provided, by the Chief, CHS Branch, IHS Headquarters, will be used to process financial transactions.

ATTACHMENT C

FUND CONTROL PROCEDURES

REQUESTING ADDITIONAL CONTRACT HEALTH CARE RESOURCES

When additional resources are requested by an Area Office, the following information will be required to consider the request.

Basic Data

Name of Area Office
Fiscal Year
Initial Annual Area Allowance
Distribution of Allowance by service unit/tribal contract
Total Annual Area Allowance to Date
Previous increases provided to current fiscal year
Amount of additional resources being requested
Narrative justification for the increase requested which includes a status report in the change of the level of medical services being provided in the Area.

CHEF DATA

Number of CHEF cases to date by service unit/tribal program including the following information:

Date CHEF funds requested
CHEF reimbursement to date
CHEF cases being processed
CHEF cases identified but not processed

SUPPORTING DOCUMENTATION

Name(e) of service unit requiring increased funds
Date Area Office identified shortfall of CHS funds
Special events which created the additional requirement
Amount of funds redistributed within the Area
Management Plan for the remaining fiscal year with and without increase in CHS funds
Copies of weekly spending rates assessment done by the service unit and Area Office

HISTORICAL INFORMATION

Initial funding, final allowances, total obligations, and total expenditures incurred for the previous three fiscal years at the site requesting additional funds:
Dollar amount of unobligated claims processed after the close of the operating year for the last three fiscal years.